ADVANCED SLEEP MEDICINE SERVICES, INC.

TOLL FREE FAX: (877) 855-6227
TOLL FREE TEL: (877) 775-3377
WWW.SLEEPDR.COM

"Better Sleep for a Brighter Tomorrow"

SERVICE REQUEST FORM AND STATEMENT OF MEDICAL NECESSITY

PLEASE FAX THIS SIGNED FORM ALONG WITH A **COPY OF PATIENT'S PROGRESS NOTES AND INSURANCE CARD** TO **(877) 855-6227**

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: ❑ M ❑ F Height _____ Weight _____

Address: _____ City: _____ State: _____ Zip: _____

Best Contact Number: (____) _____ Alternate Number (If any): (____) _____ E-Mail: _____

PRESCRIBED SERVICE(S)

(Please Check)

- ❑ 50/50 SPLIT STUDY OR IF AUTHORIZATION DENIED, UNATTENDED HOME SLEEP TEST
  CPT: 95811 OR 95800
- ❑ 50/50 SPLIT STUDY
  (POLYSOMNOGRAPHY WITH CPAP/ BIPAP TITRATION)
  CPT: 95811
- ❑ PSG (POLYSOMNOGRAPHY)
  CPT: 95810
- ❑ 2ND NIGHT STUDY DEDICATED TO CPAP/ BIPAP TITRATION
  CPT: 95811
- ❑ SERVO VENTILATION TITRATION STUDY
  CPT: 95811
- ❑ MSLT (MULTIPLE SLEEP LATENCY TEST)
  CPT: 95805
- ❑ UNATTENDED HOME SLEEP TEST, AND IF INDICATED, FOLLOWED BY COMPREHENSIVE IN-LAB SLEEP STUDY
  CPT: 95800 FOLLOWED BY 95811
- ❑ UNATTENDED HOME SLEEP TEST ONLY
  CPT: 95800
- ❑ OTHER *(PLEASE SPECIFY)*:
  _____
  _____

HISTORY & SYMPTOMS

(Please check all that apply)

- ❑ HISTORY OF WITNESSED APNEAS
- ❑ LOUD, HEAVY SNORING OFTEN INTERRUPTED BY SILENCE & GASPS
- ❑ SNORING
- ❑ OBESITY
- ❑ MORBID OBESITY
- ❑ ATRIAL FIBRILLATION
- ❑ ASTHMA, COPD
- ❑ HYPOXEMIA
- ❑ DAYTIME SLEEPINESS
- ❑ DIABETES
- ❑ SEIZURES, EPILEPSY
- ❑ HEADACHE
- ❑ OXYGEN USE AT NIGHT _____ LITERS/MINUTE
- ❑ OTHER _____

PLEASE NOTE: Based on Medicare guidelines, sleep study testing is not covered for snoring without other related symptoms.

INTERPRETATION BY

(Please Check)

- ❑ ASMS Qualified Sleep Physician *(default)*
- ❑ Other *(Please Specify Name)*:

_____

NOTE: For Medicare patients, interpreting physicians must meet Medicare required qualifications.

REFERRING PHYSICIAN INFORMATION

I certify that the above service(s) prescribed by me is/are medically indicated and in my opinion is/are reasonable and necessary with reference to all professionally recognized medical standards and treatment of this patient's condition.

Name: _____ TEL: (___) _____ FAX: (___) _____ Office Contact Person: _____ NPI Number: _____

Physician Signature: _____ Date: _____

Revised 12/17/2012